Suicide Rates in the Army Up for All Ages, Sexes

BY DAMIAN McNAMARA

ORLANDO — Psychiatrists and primary care physicians outside the military health care system have a pivotal role to play in helping to lower suicide rates, which have been on the rise across all components of the United States Army, according to according to Col. Elspeth Cameron Ritchie, MC USA.

Within the U.S. Army, suicide rates are up among all age groups and in both genders, Dr. Ritchie explained at the annual meeting of the American Association of Suicidology. Stepped-up efforts are needed to identify soldiers, reservists, and veterans who are at elevated risk.

There were about 166 suicides in the army in 2009, a rate of approximately 21 suicides per 100,000 people, or more than twice the rate in 2001.

"We have had difficulties with access to care, we have stigma, … and our services are only partially integrated," said Dr. Ritchie, medical director of the Army Medical Department's Office of Strategic Communications.

A lack of providers who accept the military health plan, TRICARE, is a barrier to those seeking care, Dr. Ritchie said, "The best way you as a provider can help is to sign up for TRICARE." Physicians who register for the program (www.tricare.mil) become a source for referrals and treatment outside of the military health care system.

Although most active and veteran military personnel receive health care services through institutions such as Walter Reed Army Medical Center and the Veterans Affairs system, there are exceptions. For example, some soldiers are students, have private insurance, or are members of the Reserves. "One of our struggles is how to provide support when they leave active duty and go back into the Reserves."

This is where private sector physicians come in, she said.

Risk factors for suicide among a military population can differ from the general population. The typical solider at risk of suicide does not have a long history of mental health issues. "What we don't see is major mental illness," such as schizophrenia or bipolar disorder, that is disabling. Only about 5% of military suicides are associated with a diagnosis of personality disorders, which is "lower than I would have expected," said Dr. Ritchie, who also is a professor of psychiatry at Uniformed Services University of the Health Sciences, in Bethesda, Md.

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Stepped-up efforts are needed to identify soldiers, reservists, and veterans who are at elevated risk for suicide, according to Col. Elspeth Cameron Ritchie.

"We are seeing more and more" suicides spurred by relationship breakups and legal problems, she said. Under such circumstances, "unfortunately, screening does not work very well. They could screen just fine but get the 'Dear John' or 'Dear Jane' letter, buy a 12 pack, and go out and shoot themselves."

Effective interventions in a military population will require a comprehensive look at all the elements around suicide, including posttraumatic stress disorder (PTSD), mild traumatic brain injury (TBI), and depression. "This is not going to be an issue for just 1 or 2 years, these are going to be issues for 20 years or 40 years," Dr. Ritchie said. "So we all need to work on this together."

The type of warfare many soldiers see when deployed in Afghanistan or Iraq increases their risk for mild TBI and associated symptoms. "The signature weapon of this war is the blast. And that causes a lot of symptoms." Re-experiencing the trauma, numbing/avoidance, and physiologic arousal ("flight or fight" response) are the three main PTSD symptom clusters.

Army research suggests that soldiers need at least 2 years of noncombat time before their symptoms of anxiety and depression begin to wane. Re-integration can be a time of elevated risk for self-harm. "They have this high adrenaline from being in theater, and they don't know what to do with it. They take out a motorcycle and drive it at 120 mph."

Traditionally, the military has relied on suicide-mitigation strategies such as buddy aid where one soldier might notice unusual behavior in another and recommend they go for help.

"I'm not saying these have not worked," Dr. Ritchie said, "It's hard to know what would have happened otherwise, but it's clear [they're] not working well enough."

The Department of Defense has mandated annual and postdeployment screening for suicide. "There is a reassessment 3-6 months after they come back because they may not be truthful right after deployment," Dr. Ritchie said. In other words, army leadership acknowledges that some personnel might minimize their feelings immediately post combat to expedite their return home.

The DOD continues to develop and promote new prevention initiatives. A task force aimed at reducing suicide is currently working on state-of-the-art, universal, multidisciplinary suicide awareness and prevention training.

Technology to augment therapy is another strategy, one designed to overcome some access to care issues in remote areas. Virtual reality programs and telemedicine are examples. "Telemedicine is not a silver bullet," Dr. Ritchie said. "It is very time intensive but can be effective."

Are these initiatives working? "It's a little early to tell; 2009 was an extraordinary year for suicide—highest they have been," Dr. Ritchie said. "It seems lower so far this year. We are holding our breath on that one." ■

Suicide Risk Doesn't Vary Across Antidepressant Drugs

BY MARY ANN MOON

The risks of attempted suicide, completed suicide, and violent suicide showed "no clinically meaningful variation" by the type of antidepressant used in a large cohort study.

"Our finding of equal event rates across antidepressant agents supports the U.S. Food and Drug Administration's decision to treat all antidepressants alike in their advisory" warning that the drugs might be associated with an increase in suicidal thoughts and behaviors, said Dr. Sebastian Schneeweiss of Brigham and Women's Hospital, Boston, and his associates (Arch. Gen. Psychiatry 2010;67:497-506).

Some studies have suggested that particular antidepressant drugs or drug classes raise the risk of suicide to a greater degree than others, but other studies have refuted that. "We sought to address whether the risk of suicide is equal across antidepressant classes and agents after adjusting for selection factors—or whether there are particular regimens with safety advantages that should be prescribed preferentially," the investigators said.

They studied all adult residents of British Columbia who initiated the use of an antidepressant medication between 1997 and 2006. They excluded patients who used buproprion because it is sometimes used for smoking cessation rather than depressive symptoms, escitalopram because it was not marketed until near the end of the study period, and duloxetine because it was not marketed in Canada during the study period.

The medications were classified as selective serotonin reuptake inhibitors (SSRIs) (citalopram, fluoxetine, fluvoxamine, paroxetine, and sertraline); serotonin norepinephrine reuptake inhibitors (venlafaxine); tricyclics (amitriptyline, amoxapine, clomipramine, desipramine, doxepin, imipramine, maprotiline, nortriptyline, protriptyline, and trimipramine); newer and atypical agents (mirtazapine, nefazodone, and trazodone); and monoamine oxidase inhibitors (moclobemide, phenelzine, and tranylcypromine).

A total of 287,543 adults were assessed for 1 year. About 5% had been hospitalized previously for a psychiatric condition, and 0.6% had made a previous suicide attempt.

During the first year, 846 adults attempted suicide (751 adults) and/or completed suicide (104 adults), yielding an event rate of 6.06 attempted and completed suicides per 1,000 person-years, they wrote.

There were no significant differences in suicide rates among antidepressant classes or among individual antidepressants. This finding held true when the data were restricted to cases of suicide attempt only, suicide completion only, and violent suicide only.

Although some researchers have posited that some antidepressants might raise suicide risks only in the first few months after they are initiated, Dr. Schneeweiss and his associates found similar results—no differences among the various antidepressants—even when the data were truncated to only 6 months of follow-up.

In initial analyses, a higher rate of suicidal events in venlafaxine users was found compared with SSRI users, but this effect was attenuated when further, more refined analyses were performed. This suggests that there was a confounding effect with venlafaxine, perhaps related to the tendency of clinicians to prescribe venlafaxine for more severe cases of depression.

The findings reinforce that "treatment decisions should be based on efficacy, and clinicians should be vigilant in monitoring after initiating therapy with any antidepressant agent," they said.

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